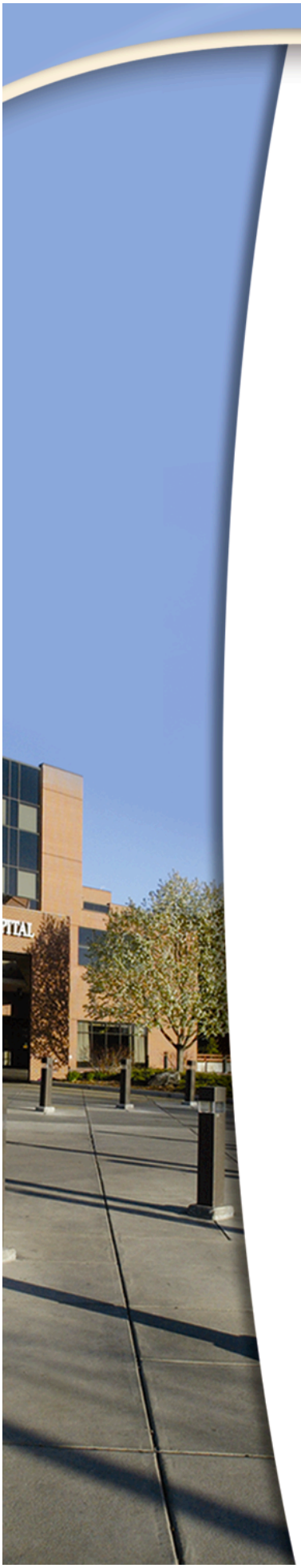

Small Rural Hospital Improvement Grant Program (SHIP)

Annual Report for FY 2005

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Rural Health Resource Center

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May 2006

EXECUTIVE SUMMARY

The Small Rural Hospital Improvement Grant Program (SHIP) annual report for FY 2005 is a summary of the use of SHIP funds by 1,591 participating hospitals as reported by the 46 participating State Offices of Rural Health (SORH) and hospitals in Puerto Rico. The information summarized for FY 2005, along with information from the FY 2002-2004 annual report summaries, provides an overview of unmet needs and current activities in small rural hospitals (under 50 beds) throughout the nation. The purpose of the SHIP grant program is to help small rural hospitals pay for the costs related to implementation of the prospective payment system (PPS), comply with provisions of the 1996 Health Insurance Portability and Accountability Act (HIPAA) and support quality improvement and the reduction of medical errors (QI).

The number of hospitals participating in the FY 2005 SHIP grant program increased to 1,591; 68 more than participated in FY 2004. The use of SHIP grant funds for reduction of medical error and quality improvement activities increased from 53 percent in FY 2004 to 60 percent. Use of grant funds for HIPAA activities decreased from 39.5 percent in FY 2004 to 34 percent and the use of funds for PPS activities remained constant at 6 percent.

Hospitals continue to identify information systems, hardware and software as the areas of highest need, followed by equipment, training and education. An inventory of health information technology (HIT) applications purchased with SHIP funds for FY 2004 and FY 2005 is included as an addendum to this report. Fewer hospitals listed HIT purchases for FY 2005 (59 percent) than for FY 2004 (72 percent). Of those hospitals using SHIP funds for HIT, 90 percent used some or all of their grant funds for HIT infrastructure in FY 2005 as compared to 70 percent in FY 2004.

SHIP funds distributed through networks, systems and consortiums increased from 10 percent in FY 2004 to 16 percent of total funds. In FY 2005, approximately $2.4 million was allocated to networks, systems and consortiums.

State Offices of Rural Health administer the SHIP grant program in their respective state. States are eligible to charge up to 5 percent for administrative costs. For FY 2005, the average state administrative charge was 3.9 percent, a 0.02 percent increase over FY 2004. SORH program goals for SHIP continue to shift from an emphasis on distributing the funds in a timely manner to providing technical assistance and coordination with other grants. SORH continue to emphasize the need to develop relationships that will lead to consortium development.

The SHIP grant program continues to fill many unmet needs of small, rural hospitals through the purchase of technology, equipment, training and education to fulfill the requirements of PPS, complying with the provisions of HIPAA, or improving quality and reducing medical error through new technology and systems.

INTRODUCTION

CONTENTS OF REPORT

This report summarizes the awarding of grant funds by State Offices of Rural Health, and use of funds by hospitals, for FY 2005, the fourth year of the Small Rural Hospital Improvement Grant Program (SHIP) with comparisons to previous years.

PROGRAM BACKGROUND

The SHIP Grant Program is authorized by Section 1820 (g) (3) of the Social Security Act. Its initial purpose was to help small rural hospitals pay for costs related to implementation of prospective payment systems (PPS). Funding for this program was first provided by the Labor/HHS Appropriations Act for FY 2002 in which conference report language expanded the purpose of this grant program to also help small rural hospitals (1) comply with provisions of HIPAA and (2) reduce medical errors and support quality improvement.

Individual hospitals do not apply directly to the Health Resources and Services Administration (HRSA) for this grant. Instead, State Offices of Rural Health (SORH) help rural hospitals to participate in the program. Eligible hospitals submit an application to their State Office; the State Office prepares and submits a single grant application (PHS 5161) to HRSA's Office of Rural Health Policy (ORHP) on behalf of all hospital applicants in the state.

ELIGIBILITY

All small rural hospitals located in the US and the Territories, including faith-based hospitals are eligible to apply through their State Office of Rural Health. For the purpose of this program:

1) "small" is defined as 49 available beds or less, as reported on the hospital's most recently filed Medicare Cost Report,
2) "rural" is defined as located outside a Metropolitan Statistical Area (MSA); or located in a rural census tract of a MSA as determined under the Goldsmith Modification or the Rural Urban Commuting Areas (RUCAs), and
3) "hospital" is defined as a non-Federal, short-term, general acute care facility. Hospitals may be for-profit or not-for-profit. Tribally operated hospitals under Titles I and V of P.L. 93-638 are eligible to the extent that such hospitals meet the above criteria.

In addition, hospitals located in an area designated by any law or regulation of such State as a rural area (or designated by such State as a rural hospital) are eligible for the SHIP grant program. All 1,279 Critical Access Hospitals are eligible for the program.

APPLICANTS

Forty-six states and one hospital in Puerto Rico participate in the SHIP grant program (Connecticut, Delaware, New Jersey and Rhode Island have no eligible rural hospitals). A complete list of participating states is attached as Appendix B.

Funding

Approximately $15 million was awarded each year for the first four grant years. In FY 2005, SORH received an average of $9,301 per hospital. As more hospitals participate in SHIP, the available grant award per hospital is reduced. The average per hospital grant award has decreased 9.7 percent since 2002 as the number of hospitals participating in SHIP has increased 9.7 percent during the same time period.

Application & award Process

State Offices of Rural Health submit a grant application to the federal government on behalf of eligible hospital applicants in the state. SORH receive the federal funds, verify hospital eligibility, make awards to all hospital applicants and ensure appropriate use of funds. Following the end of the grant period, SORH submit a financial status report to the HRSA Grants Management Office and a summary progress report (that includes individual hospital progress reports) to ORHP.

Methodology

Description of database

Quantitative and qualitative data for this report were abstracted from FY 2005, FY 2004 and FY 2003 applications from 46 State Offices of Rural Health (SORH), representing approximately 1500 hospitals, and eligible hospitals in Puerto Rico. Data for FY 2002 were obtained from the progress reports submitted by SORH and the hospitals in each state. Observations and program response information were obtained through the grant review process and from ORHP respectively.

Analysis Procedures

The collected data and information were entered into an Excel spreadsheet for analysis. A simple analysis of the numerical [quantitative] data for each year was performed that yielded totals, averages and percentages for participation and the use of funds. The narrative [qualitative] information was coded to enable simple numerical analysis. Comments and recommendations from SHIP grant reviewers were incorporated in this summary.

Limitations of Data

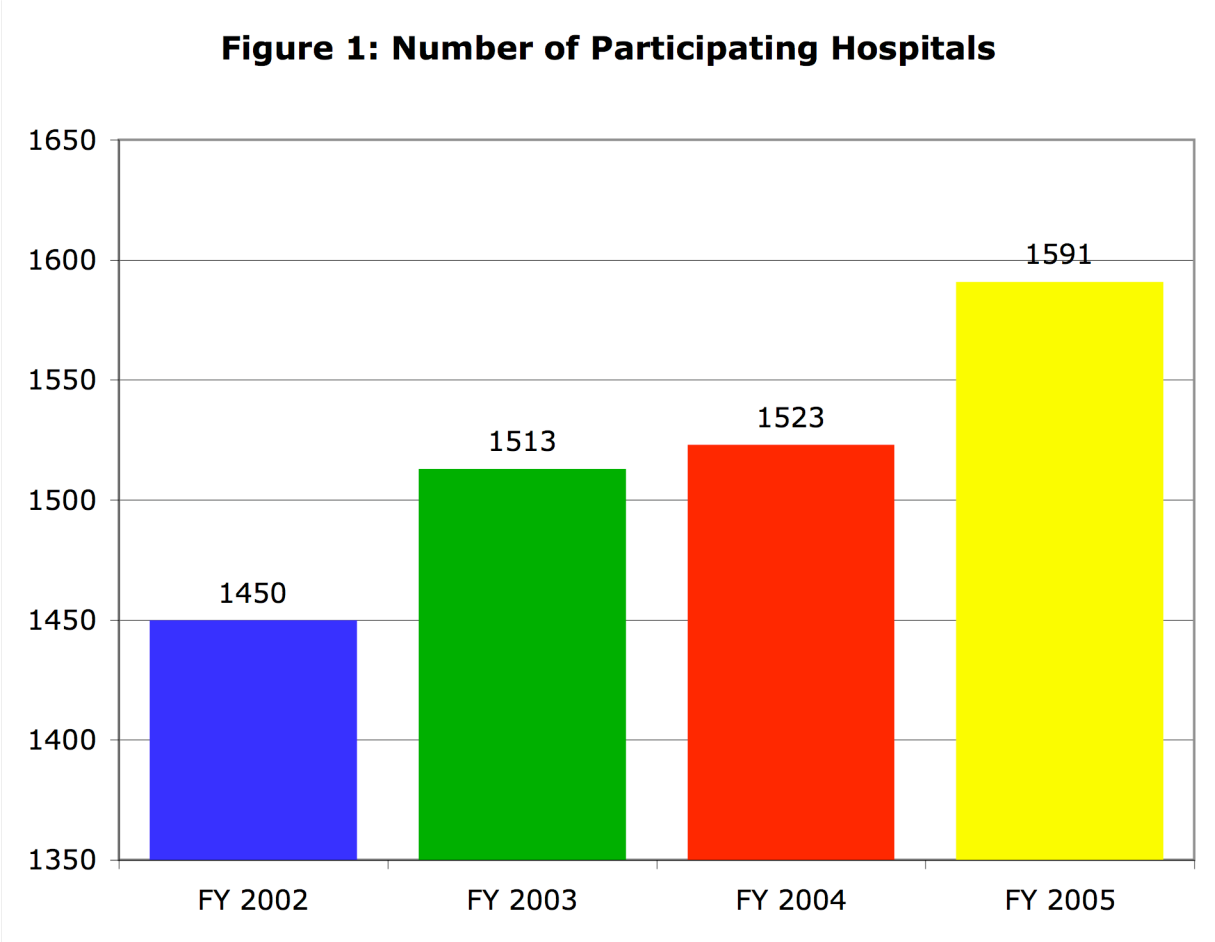
This annual report for FY 2005 is compiled primarily from the 46 SORH grant applications and progress reports which are, in effect, a summary of more than 1500 individual hospital applications and progress reports. Data for all four years were obtained from both applications and progress reports; therefore, this report should be considered an overview of the SHIP grant program to date.

RESULTS

HOSPITALS

APPLICANTS

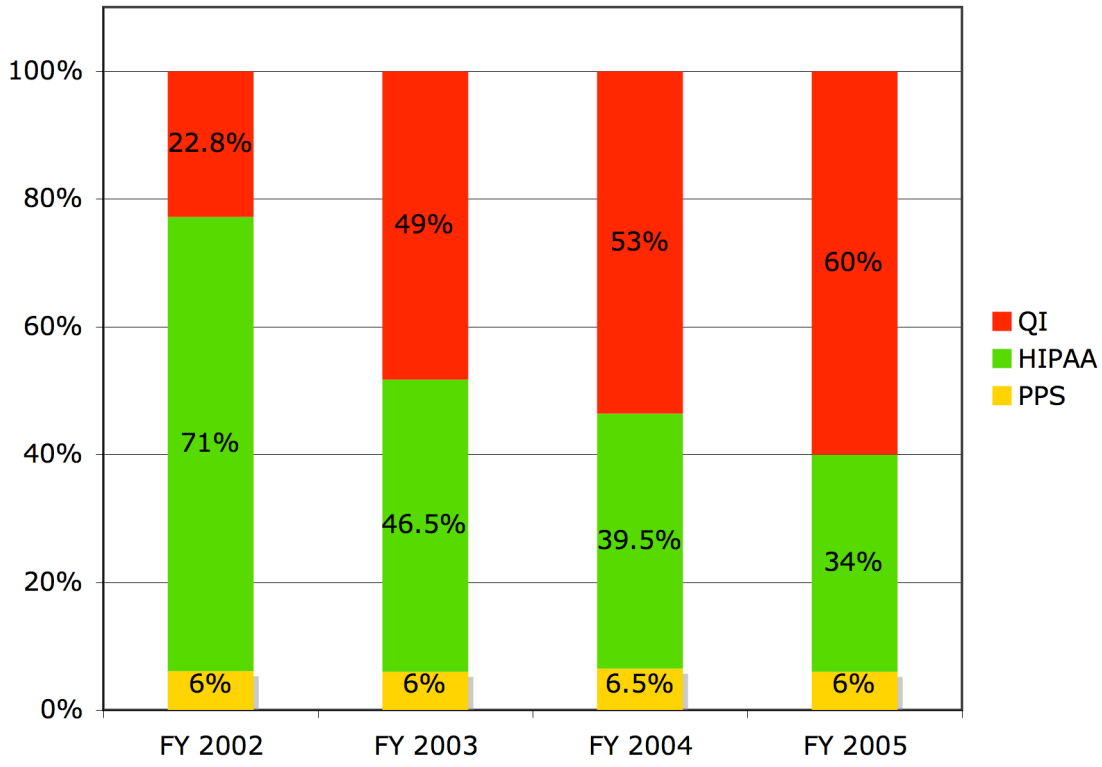
For FY 2005, applications from 46 states and Puerto Rico representing 1,591 hospitals were submitted and funded; 68 more than participated in FY 2004. This is an increase in hospital participation of 9.7 percent since 2002. (Figure 1)



USE OF GRANT FUNDS

Hospitals were asked to describe unmet needs and their use of grant funds in the areas of 1) the Prospective Payment System (PPS), 2) Health Insurance Portability and Accountability Act (HIPAA) compliance, and 3) Quality and Performance Improvement (QI). In FY 2005, PPS activities remained similar to prior years at about 6 percent, while the use of funds for QI continued to increase, rising to 60 percent, corresponding to a decline in use for HIPAA to 34 percent (Figure 2).

Figure 2: Hospital Use of Funds by Category and Year



WHAT DID THE SHIP GRANT FUNDS PAY FOR?

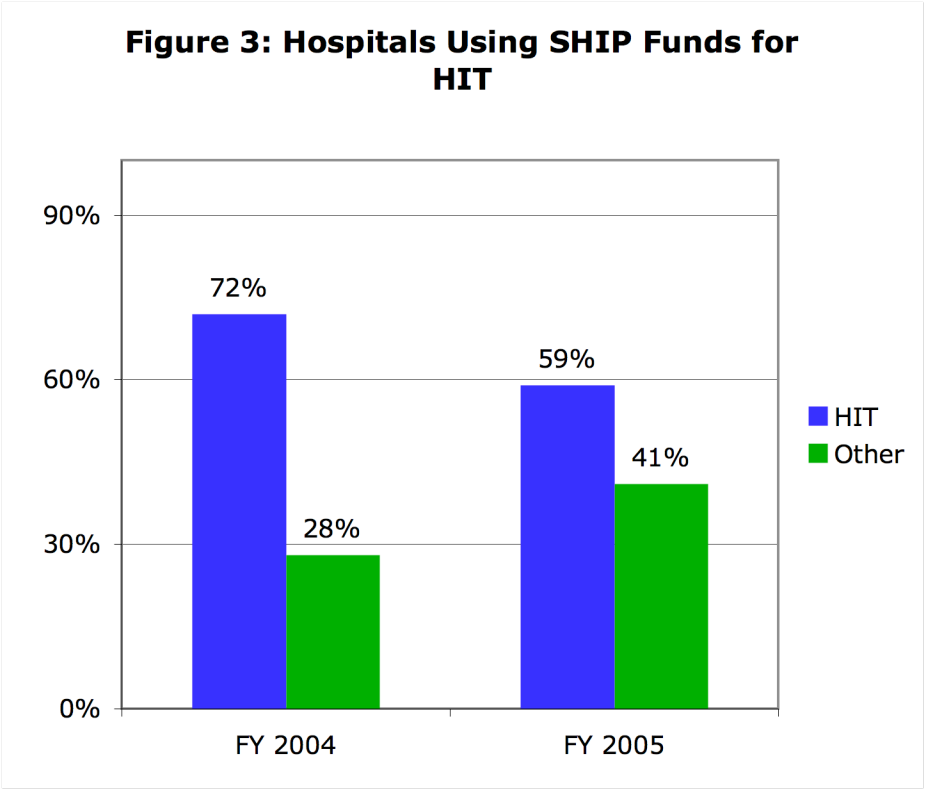
It is clear from the lists of unmet needs and anticipated/planned use of SHIP grant funds on the applications that these participating small rural hospitals have a high need for technology and information systems. There exist a wide variety of needs from desktop personal computers connected to the Internet to wireless networks with computerized order entry and electronic medical record.

For FY 2005, as in 2004, information systems, hardware and software were again identified as areas of highest need; followed by equipment, training and education. The most frequently cited expenditures for the PPS category were billing and coding software and charge-master review. In the category of HIPAA compliance, many hospitals used their funds for security software and for workspace modifications to increase privacy and security. Reduction of medical errors is an identified component of the QI category. As such, a majority of hospitals invested SHIP funds in pharmacy equipment to reduce medication errors such as bar coding, automated medication dispensing machines, computerized order entry and pharmacy management software.

To begin to understand the current status of health information technology (HIT) use in small rural hospitals, an inventory of projected use of SHIP grant funds for FY 2004 and FY 2005 was compiled (addendum). Of the participating SHIP hospitals, 941 (59

percent) in FY 2005 and 1,095 (72 percent) in FY 2004 used some or all of their grant funds to invest in HIT. Although only 154 fewer hospitals reported using SHIP funds for HIT initiatives in FY 2005, the percentage change is dramatic because more hospitals participated in SHIP in FY 2005 than FY 2004 (figure 3).

Figure 3: Hospitals Using SHIP Funds for HIT



Ninety percent of the HIT hospitals in FY 2005 and 70 percent of these hospitals in FY 2004 used some or all of their SHIP grant funds to obtain new or upgrade hardware and software infrastructure – information technology that serves as the foundation for business office, security and quality improvement functions. Approximately 10 percent of the HIT hospitals each year expended funds on hardware or software related to business office functioning such as coding, billing or accounting software. More hospitals in FY 2005 (54 percent) than FY 2004 (40 percent) identified their HIT purchases as specific to compliance with the HIPAA security rule. And fewer invested in HIT for quality improvement activities in FY 2005 (48 percent) than FY 2004 (58 percent).

Consistent with identified needs for all four years of the SHIP grant program, computer hardware and software were identified as the number one need while consultation, training, and policies and procedures were very high on the list of identified needs. Continuing the shift in emphasis from HIPAA to QI that began in FY 2003, equipment acquisition grows as an area of need. Some hospitals planned to purchase medication dispensing equipment, locking medication carts and other pharmacy equipment to reduce medication errors. Additionally, some hospitals identified the need to perform minor renovations in their nursing stations, emergency rooms or pharmacies to increase patient privacy and security. The addition of equipment as an identified need encompassed a

wide range. Some hospitals planned to use their SHIP funds to purchase locking medicine cabinets for their emergency rooms. Others were planning to invest SHIP funds in an electronic medical record system.

Hospital Network, System and Consortium Development

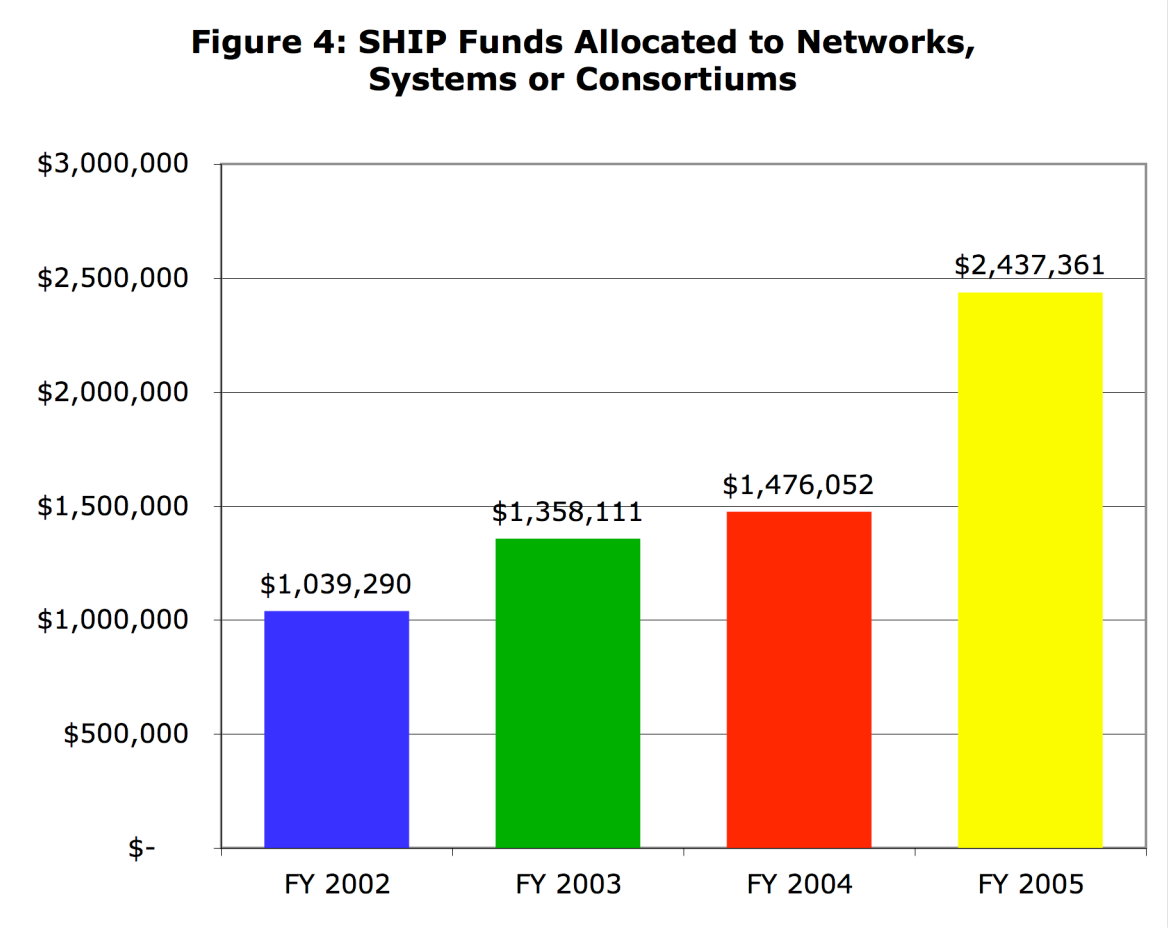
One of the goals of the SHIP grant program is to encourage hospitals to pool their grant funds in order to increase their purchasing power. It was expected that most of these grant funds would be used to purchase technical assistance, services, training and information technology. To help maximize purchasing power through economies of scale, eligible hospital grantees not already in an existing system or network were strongly encouraged to organize themselves into consortiums and pool their grant funds for the purchase of these services.

For each of the first two years, FY 2002 and FY 2003, about 25 percent of the participating hospitals either identified participation in a network, system or consortium or pooled their SHIP funds to leverage access to programs, services, consultants, and equipment. Most hospitals that pooled funds did so through existing networks or systems. Very few new networks or consortiums were formed solely for the purposes of maximizing SHIP grant expenditures.

In FY 2004, the grant application guidance was revised in an attempt to learn more about networks, systems, and consortiums. SORH were asked to list separately how many hospitals were in existing networks and how many were in SHIP consortiums. This resulted in identification of nearly 42 percent of the participating hospitals as part of a network, system or consortium; for FY 2005, SORH reported that 62.5 percent of SHIP hospitals were part of a network, system or consortium – 48 percent participate in an existing network and over 14 percent participate in SHIP consortiums.

SHIP funds invested in networks, systems or consortiums has grown to 16 percent of total funding. In FY 2005, approximately $2.4 million (of the total $15 million grant program) was invested in networks, systems and consortiums. This is an increase of 65 percent over FY 2004 (Figure 4).

Hospitals and SORH have worked diligently to realize the program goal of leveraging SHIP grant funds through investment in networks, systems or consortiums. As a result, the amount of SHIP funds allocated through systems, networks and consortiums has grown from 7 percent to 16 percent of total SHIP funds over the four-year period of the program.



Resource Sharing or Pooling

Of those hospitals that pooled funds into networks, systems or consortiums, 43 percent did so to realize cost savings through group purchasing. Seven percent of the hospitals that pooled funds cited technical assistance, collaboration or sharing a knowledge pool as the reason. Achieving administrative efficiencies was cited as a reason for pooling by 11 percent of the hospitals. One state explained that their hospitals pooled funds because they were part of an existing network that offered programs or services that the hospital could "buy into" with their SHIP funds.

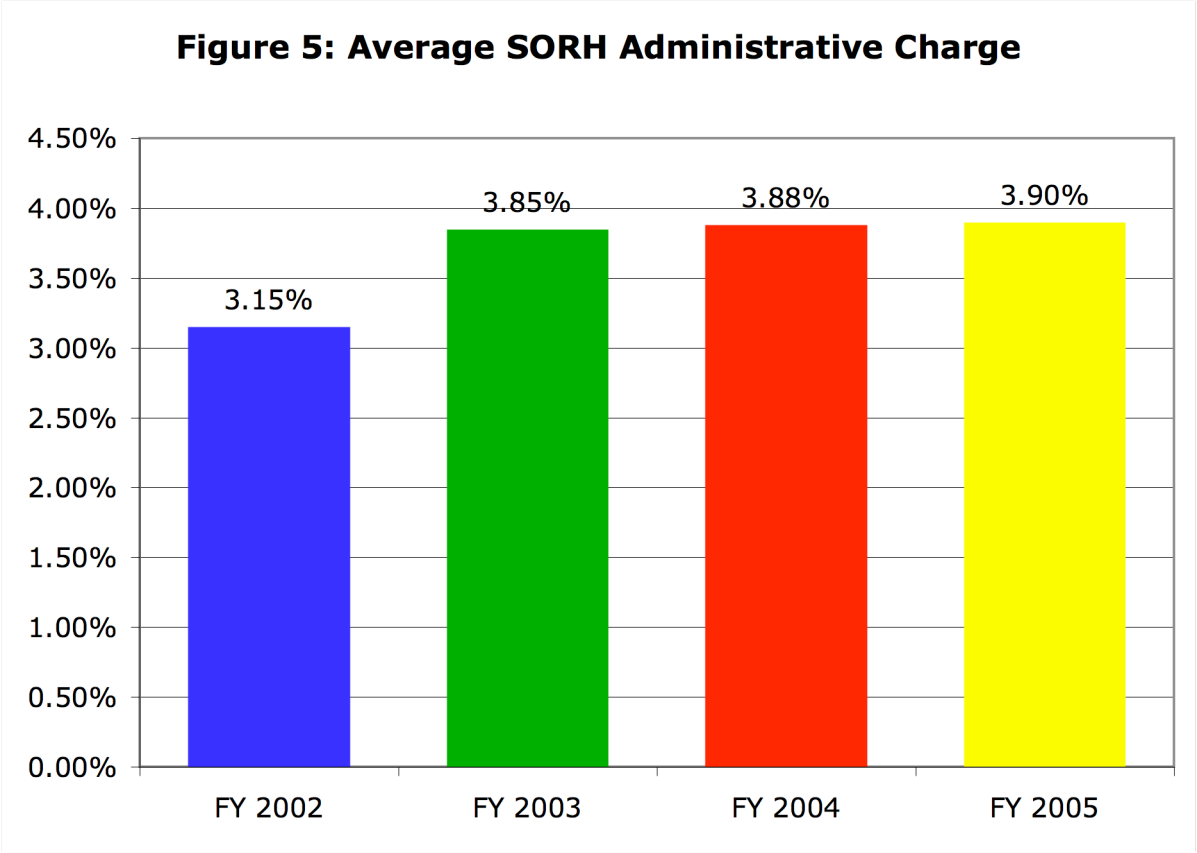
Hospitals continue to list individual hospital needs or plans, geographic isolation or working with their own affiliations (such as their network hospital or management company) as reasons for not pooling funds.

STATE OFFICES OF RURAL HEALTH

Each State's Office of Rural Health (SORH) has agreed to help the Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP) administer the SHIP grant program. SORH responsibilities are to: 1) verify hospital eligibility, 2) help eligible hospitals apply, 3) review and summarize hospital applications and progress reports, 4) submit a consolidated grant application to the federal government on behalf of hospital applicants in the state, 5) manage grant funds, 6) make awards to eligible hospital applicants, and 7) ensure appropriate use of funds.

SORH may charge up to 5 percent of the total state grant award to cover administrative costs. On average, SORH used 3 percent of the total grant award for administrative costs during the first year and nearly 4 percent for each of the second third and fourth program years (Figure 5). Some SORH do not charge any fee for administering the program; for FY 2005, 7 of the 46 states administered the program at no cost, forwarding all of the grant funds directly to hospitals or networks.

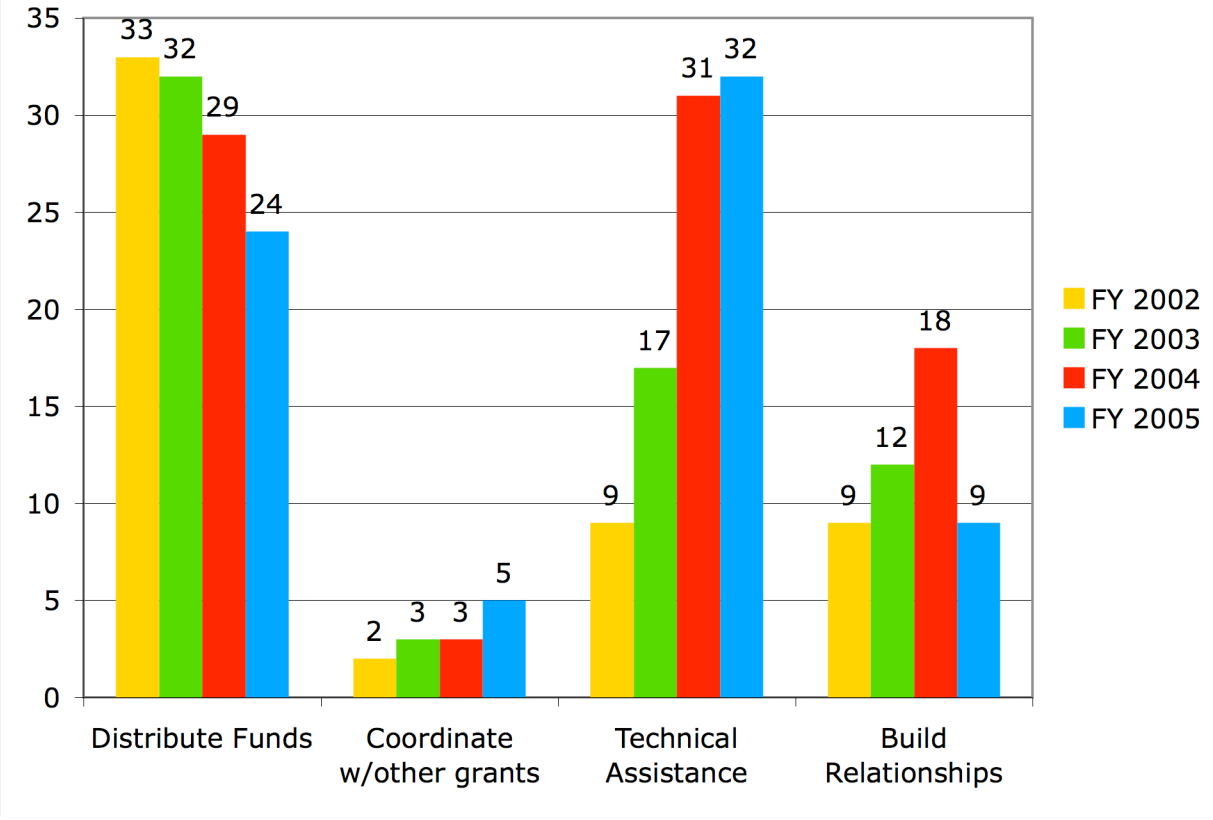
Figure 5: Average SORH Administrative Charge



Program Goals – State Offices of Rural Health

SORH stated a variety of program goals for each of the years that are broadly categorized in Figure 6. Although SORH are still focused on distributing the funds and administering the program as efficiently as possible, a shift toward providing technical assistance to hospitals to improve health care in the areas of PPS, HIPAA compliance and QI, and to assessing the value and impact of the program at the hospital level is observed. Nine of the states continue work on building relationships for the purpose of forming purchasing pools in the future.

Figure 6: SORH Reported Program Goals



SORH Recommendations to Improve the SHIP Grant Program

Nearly all SORH expressed gratitude for the SHIP grant program and recommended its continued funding. SORH and hospitals offered a variety of recommendations for the Office of Rural Health Policy (ORHP) to improve upon the SHIP program. The most common recommendation each year was for ORHP to provide technical assistance and examples of acceptable activities for each of the categories – PPS, HIPAA and QI – and provide additional information to assist in network, system and consortium development.

In response to the request for technical assistance and examples of successful SHIP funded programs, ORHP created a website with SHIP-specific information and links to related information for hospitals and SORH. The website can found at http://tasc.ruralhealth.hrsa.gov/ship.shtml and includes case summaries of successful SHIP consortium projects as well as a form for submitting a success story to share with other SORH and hospitals.

Additionally, ORHP conducts an annual technical assistance conference call coinciding with publication of the grant guidance to assist SORH to successfully navigate the application process.

APPENDICES

Appendix A: List of consortium activity by state
Appendix B: List of Number of Hospitals by State & Award
Appendix C: Map of Hospitals by State
Addendum: Hospital HIT Inventory – 2004 & 2005

APPENDIX A

LIST OF CONSORTIUM ACTIVITY BY STATE

Although all SORH report active encouragement of SHIP consortium development, fewer than half of the states have been successful in forming and maintaining such developments. The following is an alphabetical list of states that proposed using 2005 SHIP funds in a consortium, network or system and a brief description of the consortium activity.

Alaska

Alaska Small Hospital Performance Improvement Network (ASHPIN) began with SHIP funds in 2002. Ten of the 18 SHIP hospitals belong. (2003 case story)

Georgia

Hometown Health, LLC will deliver HIPAA & QI services to 21 hospitals and Georgia Hospital Association will deliver QI services to 10 hospitals. Four hospitals that belong to John D Archbold Health System will collaborate for QI services. Thirty-five of Georgia's 53 SHIP hospitals participate in the 3 different consortium activities.

Kentucky

Hospital Association Consortium of Kentucky is forming 4 regional networks for targeted projects with all 37 SHIP hospitals.

Michigan

Upper Peninsula Health Care Network (UPHCN) pool funds for SHIP projects with 9 SHIP hospitals. (2003 case story)

Montana

Montana Health Network, Inc., a long-standing eastern Montana consortium formed to provide services to rural hospitals, will work with 15 of 47 SHIP hospitals.

Nebraska

Seven SHIP consortiums that are nearly identical to the CAH networks organized through the Flex grant program serve 52 of the 66 SHIP hospitals.

Nevada

Nevada Rural Hospital Partners (NRHP) formed in 1989 to retain access to hospital-based services in rural Nevada will serve 14 of the 15 SHIP hospitals. (2003 case story)

New Hampshire

Foundation for Healthy Communities will collaborate on quality improvement and performance improvement projects with all 13 SHIP hospitals on a QI/PI project.

North Dakota

Mid-Valley Provider Network is working with four hospitals on a peer review network and 13 hospitals are working with Northland Health Care Alliance on a financial and resource management project in conjunction with the Flex grant program.

Ohio

The critical access hospital (CAH) network that also serves as a collaborative network for the SHIP grant will work with 15 of the 30 SHIP hospitals on a QI work group.

Oklahoma

Three hospitals are participating in a buying consortium; four major hospital systems serve as networks for their rural hospitals.

Oregon

The Oregon quality improvement organization (QIO), state hospital association (SHA) and SORH have developed a CAH quality improvement network that may serve as a SHIP consortium. Three hospitals have agreed to collaborate for group purchasing, currently identifying project.

Pennsylvania

A medication safety consortium working with the Institute for Safe Medication Practices includes eight of the 18 SHIP hospitals. (2004 case story)

South Dakota

Two hospitals in a SHIP consortium for group purchasing.

Utah

Six hospitals participate in two networks that will pool funds for SHIP projects.

Vermont

An Institute for Healthcare Improvement (IHI) project called IMPACT includes all nine SHIP hospitals. (2004 case story)

Virginia

Critical Access Small Hospital Integrated Network (CASH-IN) is working on a telemedicine initiative for FY 2005 with four of the 12 SHIP hospitals.

Washington

Forty-two of the 44 SHIP hospitals participate in 5 different hospital networks.

West Virginia

A consortium for peer review, patient safety and benchmarking projects includes 13 of the 23 SHIP hospitals.

Wisconsin

The Rural Wisconsin Health Cooperative works with 20 of the 50 SHIP hospitals. (2004 case story)